

UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 9

In the Matter of

HOSPITAL GENERAL MENONITA, INC.

Employer

and

Case 9-RC-17602
(Formerly 24-RC-8204)

FEDERACION CENTRAL DE TRABAJADORES
UFCW, LOCAL 481, AFL-CIO ^{1/}

Petitioner

DECISION AND DIRECTION OF ELECTION

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, as amended, herein called the Act, a hearing was held before a hearing officer of the National Labor Relations Board, herein called the Board.

Pursuant to the provisions of Section 3(b) of the Act, the Board has delegated its authority in this proceeding to the undersigned.

Upon the entire record in this proceeding, ^{2/} the undersigned finds:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.
2. The Employer is engaged in commerce within the meaning of the Act, and it will effectuate the purposes of the Act to assert jurisdiction.
3. The labor organization involved claims to represent certain employees of the Employer.
4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

^{1/} The name of the Petitioner appears as amended at the hearing.

^{2/} The Employer and the Petitioner timely filed briefs which I have carefully considered in reaching my decision.

5. The Employer is engaged in the operation of an acute care hospital at Cayey, Puerto Rico, also referred to herein as the hospital, where it employs approximately 500 employees, including about 80 registered nurses (RNs) in the unit found appropriate.

The record reflects that on the first day of the hearing in this matter, the parties entered into a Stipulated Election Agreement in Case 24-RC-8205. The petition in Case 24-RC-8205 seeks a unit of technical employees and shows that there are approximately 68 employees in that unit. The record does not contain any further evidence of bargaining history affecting any of the employees at the hospital.

In the subject case, the Petitioner seeks to represent a unit of all regular full-time and part-time staff RNs employed by the Employer at its Cayey, Puerto Rico facility. The parties stipulated that all other employees, managerial employees, guards and supervisors as defined by the Act are properly excluded from the unit sought. Inasmuch as neither party made any contention on the record that a unit of registered nurses at the hospital is not appropriate, I find that it is an appropriate unit for purposes of collective bargaining pursuant to the Board's Rule for acute care hospital units. See the Board's Final Rule on Collective-Bargaining Units in the Health Care Industry, 29 CFR Part 103, 54 Fed. Reg. 16348, Section 103.30(a)(1), reprinted at 284 NLRB 1579, 1597 (1989).

The Employer, contrary to the Petitioner, maintains that all RNs who work at the hospital, as a class, are supervisors within the meaning of Section 2(11) of the Act. The overall supervisory status of the RNs was the only issue identified on the record.

OVERVIEW:

The nursing operations at the hospital are headed by Maria Colon, administrative aide, who reports directly to the administrator, Pedro Melendez. Reporting directly to Colon is Jose Arroyo, nursing services director, who supervises the nursing areas.^{3/} Colon testified that there are 10 nursing areas and 10 department supervisors who are RNs. The Employer's organizational chart for its nursing operations^{4/} reflects that there are 10 departments under Arroyo: medical emergencies, emergency room (ER), admissions, nursery/delivery room, medicine, intensive care (ICU), pediatrics/surgery, operating room (OR), OB/GYN (also called intermediate) and dialysis.^{5/}

^{3/} The nursing areas are also referred to on the record as departments and units.

^{4/} Employer's Exhibit 2.

^{5/} This departmental structure is inconsistent with the Employer's overall organizational chart (Employer's Exhibit 1) which shows dialysis directly under Melendez but not under Colon or Arroyo and shows admissions directly under Colon but not under Arroyo. This departmental structure is also inconsistent with record testimony concerning the telemetry department in which nursing personnel work. Telemetry is shown as being included in nursing operations on the overall organizational chart but is not shown on the nursing organizational chart. It would appear, therefore, that telemetry is an 11th nursing department. Although the 11 nursing departments are collectively referred to on the record as the nursing department, for the sake of clarity, I shall refer to them collectively as the nursing operations.

Petitioner's Exhibit 2 is a job description and evaluation form for an area supervisor which describes the duties of the incumbent as being responsible for directing and supervising nursing services in the assigned area.^{6/} The record identifies Adelaida Alejandro as the ICU area supervisor, Carmen Rodriguez as the OR area supervisor, Wanda Morales as the Telemetry area supervisor, Ms. Luna as the nursery/delivery room area supervisor, Diane Delgado as the pediatrics/surgery supervisor and Irma Colon as the medicine area supervisor.^{7/} Maria Colon testified that the OB/GYN and dialysis departments have licensed supervisors and that the dialysis supervisor is an RN.^{8/} Marisley Rodriguez, the RN in charge of admissions, is not an area supervisor. The record reflects that the emergency room department is headed by an area supervisor but does not identify that person by name.^{9/} There are no RNs who work in the medical emergency department which Colon directly supervises. All area supervisors work from 7 a.m. to 3 p.m., Monday through Friday.

Ms. Ortero, Ms. Vasquez and Mr. Green are the permanent general supervisors for the hospital. They work shifts from 7 p.m. to 7 a.m. on weeknights as well as from 7 a.m. to 7 p.m. and 7 p.m. to 7 a.m. on weekends. The job description and evaluation forms for area supervisors and the emergency room coordinator reflect that they are assigned to general supervision one weekend per month. The record further shows that area supervisors rotate covering general supervision from 3 p.m. to 7 p.m. on weekdays and that some staff RNs^{10/} may be called upon to fill in for general supervision on an ad-hoc basis. The record indicates that there is one general supervisor per shift to perform supervisory duties over the entire hospital and that there is a general supervisor on duty at all times except from 7 a.m. to 3 p.m. on weekdays when nursing management (Colon and Arroyo) is present.

^{6/} Area supervisors are also referred to on the record as department supervisors and unit supervisors.

^{7/} The record reflects that Irma Colon was the medicine area supervisor in the Spring of 2001 and contains no evidence that she does not currently hold that position.

^{8/} Inasmuch as Colon testified that there are 10 nursing areas and 10 department supervisors, it is likely that the OB/GYN department and dialysis department supervisors are, in fact, area supervisors, but the record does not state this fact with certainty, nor does it identify them by name.

^{9/} The record shows that there are two supervisors in the emergency room. Hector Rivera is the emergency room coordinator who works from 3 p.m. to 11 p.m. and whose job description and evaluation form describes him as being responsible for acting as supervisor on his shift. Mr. Munoz was identified as being an emergency room supervisor who works from 7 a.m. to 3 p.m. which are the same working hours as the other area supervisors. The nursing operations organizational chart shows that the emergency room nurse coordinator reports directly to the emergency room supervisor. It is likely, therefore, that Munoz is the emergency room area supervisor, but the record does not state this fact with certainty.

^{10/} Both parties referred to area supervisors and general supervisors as being supervisors. Colon testified that the admissions department did not have a supervisor assigned to it but the hospital had a registered nurse who works there on an independent basis and who is in charge of the EKG technician. Thus, both parties made a distinction between those RNs who are called supervisors and those who are not. Staff RN is a reference to RNs who are not called supervisors. For the sake of clarity, I make the same semantic distinction in the recitation of facts. Such labels, however, do not affect my deliberations as to whether the staff RNs are, in fact, statutory supervisors within the meaning of Section 2(11) of the Act.

The general supervisors and area supervisors are RNs. The parties stipulated, the record reflects, and I find that Pedro Melendez, administrator; Maria Colon, administrator aide; Adaraida Alejandro, ICU area supervisor; Carmen Rodriguez, OR area supervisor; and Wanda Morales, telemetry area supervisor; are supervisors within the meaning of Section 2(11) of the Act. Accordingly, they are excluded from the unit found appropriate. Because the only issue framed on the record was whether the RNs as a class are supervisors, the record does not indicate whether the supervisory status of the area supervisors and the general supervisors is otherwise in dispute. Similarly, the record does not reflect whether the supervisory status of Hector Rivera, ER coordinator; Sonia Rivera, RN in charge of sterile supply; or Marisely Rodriguez, RN in charge of admissions is in dispute.

The hospital employs approximately 80 RNs but the record does not specify whether the area supervisors are included in this number.^{11/} Within the nursing operations there are about 35 LPNs, 10 technical employees, 10 clinical coordinators and an unspecified number of escorts. The evidence sheds partial but not complete light on how these employees are distributed among the various nursing departments. The RNs work 12-hour shifts mostly beginning or ending at 7 a.m. The remaining employees work 8-hour shifts, which normally begin at 7 a.m., 3 p.m. or 11 p.m.

With respect to the question of supervisory status of the nurses, there is no testimony regarding the hiring, transfer, suspension, lay off, recall, promotion or discharge of employees or the adjustment of their grievances.^{12/} There is substantial evidence, however, concerning employee evaluations and discipline as well as the assignment and direction of their work.

The job description and evaluation form for area supervisors, as previously noted, describes their duties as being responsible for directing and supervising nursing services over specific areas of the hospital. Their job descriptions indicate that they, among other things, classify patients (apparently on the patient classification forms admitted in evidence and more fully discussed below); make up employee work schedules (the weekly schedule more fully described below); make up a daily work schedule taking into consideration the skills and knowledge of employees; verify that the work schedule is carried out; verify that employees are properly uniformed; interpret departmental and institutional rules for employees and verify compliance; evaluate employees in their performance with patients; use strategies to evaluate employee performance; keep records for purposes of employee evaluations; refer employees with

^{11/} RNs are also referred to in the record as graduate nurses, graduate personnel, generalist nurses and associate nurses. A generalist nurse possess a 4-year nursing degree while an associate nurse possesses a 2-year nursing degree, but there is no difference between the two in terms of the authority they may have over other employees. At the outset of the hearing, Colon referred to the area supervisors merely as generalist nurses. It was not until later in the hearing that Colon identified them for the first time as area supervisors. Thus, some of Colon's references to RNs included the area supervisors while other references did not. LPNs are also referred to on the record as practical nurses or practical personnel. Clinical coordinators are referred to as secretaries, clerical employees and ward clerks. Escorts are referred to as orderlies.

^{12/} The job description and evaluation form for the nursing services director indicates that the person holding that position is responsible for those personnel functions and maintains personnel files. The hospital's employee handbook contains a description of its "just listen" program in which employees may submit problems or complaints orally or in writing to their immediate supervisor or hospital administration. The description of the program does not contain any references to staff RNs participating in the consideration of submissions made by other employees.

deficiencies for training; use on-the-job training; participate in emergency departmental events by observing and evaluating employee performance and recording what occurs; make up a work scheme of planning and organization of responsibilities for weekly submission to the department director (apparently the nursing director); prepare employee time cards; fill out sheets for authorized overtime and per diem payments; perform annual employee evaluations; document and follow up on risk events; participate in orientation of new employees; verify that work team responsibilities are carried out; review and maintain administrative and procedural manuals; and prepare rules for the department. In addition to these duties, the orientation guide for new area supervisors indicates that employee interviews are a subject of their orientation, but does not explain the area supervisors' role with respect to those interviews. The orientation guide also indicates that area supervisors decide patient care priorities. Other subjects covered by the orientation guide include the Employer's personnel policies but the guide does not indicate whether the area supervisors are responsible for administering such policies or are merely informed of them during orientation.

The job description and evaluation form for general supervisors describes their duties as being responsible for general supervision of the nursing department (nursing operations) and representing the director (apparently the nursing director) during the work shift. The form indicates that the general supervisor, among other things, receives and turns over shift change reports; completes rounds in all areas at the beginning and end of the shift; makes adjustments to insure adequate staffing without affecting service; makes sure that employees take and record their breaks; follows up on patient situations; insures that admissions comply with nursing standards; ensures that patient files are complete as to transfers, releases and deaths; makes sure that employees are properly uniformed; supervises employees to insure that the care provided is top quality; submits a weekly action plan for planning and organization of responsibilities to the department manager; follows personnel standards to ensure a climate that values team work; checks the narcotics count; identifies, reports, documents and follows up on risk events; participates in orientation and follow up for new employees; provides on-the-job training; insures that employees make good use of materials and equipment; maintains employees' files for evaluation purposes; refers employees for training; participates in all emergency events and observes, evaluates and documents employee performance during such events; completes forms for authorized overtime and per diem payments; documents and follows through with employees who have special problems and reports situations to the area supervisor; consults with the department director regarding out of control employee situations for referral in cases which require direction and guidance; performs evaluations for fixed shift employees^{13/}; verifies and reports patient transfers; checks diets to insure they are correct; and verifies that laboratory requests are processed. Testimony reflects that from 3 p.m. to 7 a.m. the following day, employees contact the general supervisor concerning matters that would normally be handled by the employees' area supervisor.

The job description and evaluation form for the ER coordinator, Hector Rivera, describes him as being responsible for the general coordination of nursing services and acting as supervisor

^{13/} Although the term fixed shift employees is used frequently on the record, it is not defined. Some RNs work rotating 12-hour shifts. Thus, it is possible that fixed shift employees refers to employees who work the same hours each day and do not rotate their shifts.

for the 3 p.m. to 11 p.m. shift in the emergency room. The form shows that Rivera, among other things, receives and submits shift change reports and does rounds to insure continuity in supervision of nursing services; ensures that there are sufficient employees on duty and that they take and record their breaks; ensures that the narcotics count is performed; prepares the weekly work schedule; supervises the performance of employees; makes patient transfer arrangements; adjusts employees' work schedules; submits incident reports to the area supervisor and follows up on incidents; refers problems to the area supervisor after compiling background data; consults with the department director regarding professional assistance for all employees; prepares daily assignments according to employees' abilities; refers employees for training; and offers and documents on-the-job evaluations for employees.

The nursing director meets monthly with general supervisors, area supervisors, the ER coordinator and the coordinator of the program to improve organizational performance. The record does not disclose the purpose of these meetings or the subjects discussed. Staff RNs do not attend these meetings unless they are serving as an acting supervisor. The area supervisors meet daily at 7 a.m. for about an hour with the night shift general supervisor to receive a report of what transpired on the night shift.

The job description and evaluation form for associate registered nurses (2-year degree) describe their duties as working under the supervision of the general nurse (RN with a 4-year degree) to provide a high quality service. The evaluation form indicates that associate RNs, among other things, collect data for admissions patients' estimates and cooperate with the general RN in planning nursing care; make nursing estimates for assigned patients; execute delegated aspects of care plan; make nursing intervention considering medical orders^{14/} and other members of the health team; participate with discharge plan coordinator and social worker in implementing discharge plans; transcribe and execute medical orders; make entries in the medication cardex and the treatment cardex^{15/}; administer medication and identify adverse reactions; identify and document risk events; delegate nursing actions to members of the work team and evaluate their execution; participate in the development of skills of co-workers; and act as a leader nurse in emergencies.

The job description and evaluation form for general RNs state that they are responsible for providing a high quality of care through efficient performance of their duties. The evaluation form indicates that in addition to those duties performed by associate RNs, the general RNs, among other things, analyze admissions data to establish a nursing diagnosis and patient needs; activate a care plan based on the diagnosis and needs; re-evaluate care plans according to nursing estimates; and act as nurse leader whenever assigned.^{16/}

^{14/} Medical orders are patient care orders issued by a physician.

^{15/} A cardex is a recordkeeping system kept in each department in which RNs record patient care information for the purpose of allowing access to that information by other employees in the department. It appears that the cardex is different from a patient's medical file or chart in that the cardex contains information concerning all patients occupying the department.

^{16/} The record contains references to leader nurses, charge nurses, nurses who assume the leadership and nurses in charge, but does not indicate whether those references mean the same thing. For sake of clarity, I will use the term charge nurse to denote this reference. The record was not developed regarding the role of charge nurses, whether

The Employer also has supplemental evaluation forms for RNs in specific departments.^{17/} Functions evaluated in these supplemental forms relate solely to the administration of specific patient care tasks and do not relate to RNs' interaction with other non-physician employees; except for surgery department RNs delivering patients to the nurse in charge of the patient, accompanying the escort in such transfers and supervising work of LPNs and escorts; recovery room RNs in the OR department supervising work of LPNs and escorts and accompanying escorts in patient transfers; RNs in the operating room helping OR technicians to prepare surgeries and receiving/recording pathology information from technicians.

The orientation guide for associate RNs and general RNs is the same. Among the subjects included in that document are the Employer's personnel policies. The guide does not indicate whether RNs are responsible for administering such policies or are merely informed of them during orientation.

Although record testimony reflects that there is no difference between associate RNs and general RNs in terms of any authority they may have over employees, the job description and evaluation forms indicate that general RNs establish nursing diagnoses, determine patient needs, re-evaluate patient care plans and act as nurse leader in non-emergency situations. Such functions are not listed on the job description and evaluation forms for associate RNs. The record does not reflect a break down in the number of general RNs and associate RNs employed at the hospital.

The job description and evaluation form for LPNs describes their duties as providing nursing care to assigned patients in accordance with practical nurse standards established in different service units performing work under the supervision of the general nurse (RN). The form indicates that LPNs measure and document vital signs, establish priorities to offer patient care, identify and report changes in the patient to the RN, administer personal hygiene to patients, make beds, feed patients, handle patients with urinary probes, collect urine, fecal and culture samples, administer enemas, document and change positions of bedridden patients, measure and document patients' ingestion and elimination, change bandages, assist patients when ambulating, handle cadavers, prepare patients for medical tests and surgeries, help patients during medical examinations and measure and document medical equipment output.

FACTUAL SUMMARY:

(a) Evaluations:

The job description and evaluation form for the nursing services director indicates that the person holding that position is responsible for preparing and delivering annual evaluations of

the hospital has permanent charge nurses, which departments might have charge nurses, whether any particular department has a charge nurse designated at all times or only as needed, how charge nurses are designated or who might make such a designation. The record indicates that under some circumstances a nurse might "assume the leadership" but does not explain how that happens except that the nurses decide it among themselves.

^{17/} LPNs do not have department specific evaluation forms.

employees in nursing operations. The testimony and the evaluation forms indicate that they are used to determine merit wage increases. However, Colon testified that staff RNs do not affect wage increases for OR technicians, and the record is silent as to whether staff RNs may affect wage increases of other employees.^{18/} Colon testified that all fixed shift employees are evaluated by area supervisors and general supervisors; that RNs participate in the evaluation of LPNs, technicians and clinical coordinators by making oral recommendations to supervisors^{19/}; that she (Colon) looks at the evaluations before they are discussed with employees; that the staff RN in admissions and the staff RN in sterile supplies do the evaluations for technicians in those areas.

Alejandro is the ICU area supervisor. She testified that in performing evaluations, she uses oral recommendations of staff RNs, who substitute for her (Alejandro), as to the performance of other staff RNs on those occasions.

An evaluation form for Iris Rivera, EKG technician, was signed on October 5, 2000 by Marisley Rodriguez, staff RN in charge of admissions, as evaluator and supervisor. The form was initialed by Colon on April 10, 2001 and was signed by Rivera, the EKG technician, on May 10, 2001. Colon testified that she (Colon) initialed the evaluation form reviewing and revising it before it went to the employee. Colon did the evaluation for the EKG technician for 1998/1999.

(b) Discipline:

The job description and evaluation form for the nursing services director reflects that the person holding that position is responsible for promoting the development of personnel through positive stimuli and correcting conduct. It reflects that the nursing services director evaluates situations and recommends corrective actions. Colon testified that the nursing services director is responsible, in consultation with Colon, for the discipline of employees in nursing operations. The Employer has a standard incident report form which may be completed by any employee at the hospital and submitted to an area or general supervisor for investigation and follow up action. Although there is no English translation of the copy of the blank form in evidence, the Spanish version of the form appears to contain spaces to enter the type of problem, a brief description of the problem, the employee's version of the problem and recommendations.

There are no examples of completed incident report forms in evidence. The only example of an actual incident report in the record is not contained on an incident report form but is a narrative account prepared on October 5, 1999 by Wanda Claudio, a staff RN (apparently in telemetry) and submitted to Wanda Morales, telemetry area supervisor, concerning LPNs failing to record a particular patient's vital signs on October 1, 1999. The narrative incident report indicates that on October 1, 1999, Claudio informed several LPNs of the importance of recording

^{18/} When asked whether staff RNs may affect the wages of other technicians, Colon testified that the RN does not intervene with relation to salaries. However, the record is unclear whether Colon was referring to intervention with technicians in particular or employees in general.

^{19/} The staff RNs who were called as witnesses by the Petitioner testified generally that they do not have input in the evaluations of other employees.

vital signs and specifically instructed two LPNs to record vital signs they had already taken from the patient.^{20/} There was no indication on the narrative report or elsewhere in the record that any discipline issued as a result of this incident. Colon testified that RNs use incident reports to report an LPN's failure to carry out a task and that RNs may attempt to correct work deficiencies of OR technicians and report the deficiency to a supervisor who then undertakes an investigation. Alejandro, the ICU area supervisor, testified that a staff RN substituting for her (Alejandro) could not impose discipline but could investigate the matter and report it to Alejandro and that general supervisors refer disciplinary matters to area supervisors. Olga Navarro, a staff RN in telemetry, testified that she completed an incident report concerning the pharmacy department's mistake in a patient's medication but that she had no involvement in the matter after submitting the incident report to her supervisor. Similarly, Wanda Rivera, a staff RN, testified that she submitted an incident report to her area supervisor concerning a sleeping emergency room physician's failure to see a patient, but that she had no further input regarding the incident.

The record does not contain evidence of any disciplinary actions issued to any employees. The staff RNs do not have access to the personnel files of other employees.

(c) Assignment:

The job description and evaluation forms for area supervisors indicate that they are responsible for preparing the weekly and daily work schedules. The weekly work schedule forms are prepared by the area supervisors for their respective departments but they must be approved by Colon. The schedule shows the shifts during a particular week the employees are scheduled to work. The weekly schedule for staff RNs is prepared separately on a separate form from the weekly schedule for LPNs. The record does not reflect whether a weekly shift assignment schedule is prepared for clinical coordinators, technicians or escorts.

Some of the weekly schedules for staff RNs designate which RN is responsible for the narcotics count or crash cart (mobile cardiac arrest equipment) assignment, but other weekly staff RN schedules do not specify those assignments. The weekly RN schedules may occasionally designate a staff RN to be the leader of or supervisor for a particular shift in a designated department under circumstances which are not disclosed in the record. The weekly assignment sheets in evidence indicate that such leadership assignments are infrequent.

RNs work 12-hour shifts beginning or ending at 7 a.m., except for a few RNs in the emergency room who work 12-hour shifts beginning at 11 a.m. The most recent weekly assignment sheets for RNs admitted in evidence were for the week of October 7, 2001. Those documents reflect that 13 RNs were assigned to the ICU department with 3 RNs per shift except for Saturday day shift and Thursday night shift when there were only 2 per shift; that there were 27 RNs assigned to the emergency room; and that there were 12 RNs assigned to telemetry (third

^{20/} In its brief, the Employer maintains that Claudio's instructions to the LPNs to record the vital signs demonstrates that RNs assign and direct the work of LPNs. However, for reasons more fully set forth below, I conclude that Claudio's instructions did not require the use of independent judgment because the record clearly demonstrates that the LPNs are routinely responsible for measuring and recording patients' vital signs, thereby obviating Claudio's use of discretion in issuing the instructions.

floor) with 3 RNs per shift except for the Monday and Wednesday night shifts when there were only 2. In addition to the information contained on these weekly assignment sheets, testimony reflects that a staff RN works in admissions, 12 staff RNs work in the medicine department (second floor), 8 staff RNs work in the OR department, 1 or 2 staff RNs work in the OB/GYN department (fourth floor); and 3 or 4 staff RNs work in the nursery/delivery room department (fourth floor). The record is unclear as to how many RNs work in the pediatrics/surgery department (fourth floor). There is no evidence as to how many RNs work in dialysis. There are no RNs in the medical emergency department, which is staffed by three emergency medical technicians who report to the nursing director and the ER area supervisor.

Admitted in evidence were copies of weekly schedules for LPNs assigned to the second floor (medicine department), third floor (telemetry department) and fourth floor (pediatric/surgery department, nursery/delivery room department and OB/GYN department) for the week of October 14, 2001, as well as the third floor LPN weekly assignment sheet for the prior week. These records show that during the week of October 14, 10 LPNs were assigned to each of these three floors to work 8 hour shifts beginning at 7 a.m., 3 p.m., or 11 p.m. The 10 LPNs who worked the third floor that week were the same 10 LPNs who worked the third floor the prior week. The staffing totals at the bottom of these documents show that the second floor had 2 LPNs per shift, except for Tuesday and Wednesday day shift which had 3 LPNs; that the third floor during both weeks had 2 LPNs per shift except for Monday, Tuesday, Friday and Saturday day shift when 3 LPNs were present and Sunday night shift when 1 LPN was present; and that the fourth floor had 2 LPNs per shift on day and afternoon shifts with 1 LPN per shift at night. Colon testified that she reviews and revises these weekly schedules for LPNs. In addition to the LPN staffing levels reflected on the weekly schedules, testimony indicates that an LPN phlebotomist works in the ER as well as on patient floors taking blood samples and that there is an LPN assigned to the OR department. There are no LPNs assigned on a permanent basis to the admissions department, the nursery/delivery room department, or the ICU department. However, an LPN may be temporarily assigned to nursery/delivery or ICU if patient volume requires, but the record does not reflect how these temporary transfers are accomplished or how frequently they happen.

The nursing operations use a standardized patient classification form for hospitalized patients.^{21/} This form may be completed by a staff RN, an area supervisor or a general supervisor, but the record indicates that most of them are completed by staff RNs. A standard patient classification form is prepared every 12 hours for each department in which patients are assigned beds and one form is used to classify all patients in a particular department. The standard form is used to assign a numerical value to the degree of assistance a patient will require in eating, eliminating, ambulating (including change of position for bedridden patients) and personal hygiene; the complexity of medications and treatments administered; the patient's coherence; the patient's educational requirements; and the frequency of patient estimates. The numeric values from these categories are added to produce a total which is used to assign an overall categorization reflecting the level of nursing care that the patient will require, with one being the lowest level and four being the highest. The overall category assigned to the patient is

^{21/} The patient classification form is also referred to as the patient categorization form.

used, as more fully described below, to equalize the daily workload assignments among nurses on a particular shift in the various departments.

The ICU department does not use the standard patient classification form. Instead, the ICU has a patient classification grid located on its daily assignment sheets which is used to classify ICU patients in categories similar to but different from the categories used in the standard form. In general, the difference between the standard form and the ICU form is that the latter accounts for assistance to patients connected to a greater amount of tubes and machinery. The ICU form also provides for totaling various categories to calculate an overall numeric category for the patient for purposes of equalizing the work load among RNs in the ICU. The six ICU daily assignment sheets in evidence are dated between March 2, 2001 and September 20, 2001; each bears the apparent signature of both a staff RN and Alejandro, the ICU area supervisor. In addition, it appears that some of the forms were completed by two or more individuals.

Information from the weekly schedules concerning which employees are assigned to a particular department and shift are used to complete the daily assignment sheets. The daily assignment sheets assign employees to particular areas or to patients within a department and to special tasks which must be accomplished each day or shift.

The Employer uses a standard daily assignment sheet form to assign patients to nurses (RNs and LPNs) on the second, third and fourth floors of the hospital. The blank form contains entries for dividing RNs and LPNs into work teams ^{22/} on both of the 12-hour RN work shifts each day and the teams are assigned to provide care for a patient or a group of patients. The blank form also lists specific tasks to be performed by RNs and another list of tasks to be performed by LPNs. Colon testified that the daily assignment sheets may be completed by an area supervisor, a general supervisor, or a staff RN, but she does not explain the circumstances under which a staff RN, as opposed to an area or general supervisor, might perform that task. The six completed standard daily assignment sheets in evidence ^{23/} are dated between April 23, 2001 and October 14, 2001 and are all signed by staff RNs. ^{24/} These six daily schedules reflect that an RN may work alone or may be paired with one LPN to provide care to an assigned group of patients. They show that of 34 RN assignments, 13 were assigned to work with LPNs. None of the specific tasks within the RN list of tasks or the LPN list of tasks was checked on these forms, indicating that the tasks are standardized and do not require any specific assignment. These documents and the testimony reflect that RNs and LPNs may be temporarily moved from one department to another depending on patient volume in the departments involved, but the record does not reflect how these temporary transfers are made. RN assignments to narcotics count and crash cart are made on a rotational basis and some of those assignments are reflected in the weekly assignment sheets while others are shown on the daily assignments.

^{22/} The record contains testimony about nurses working together in teams, but does not contain any detail as to how the teams are structured or how they function.

^{23/} Employer's Exhibits 30(a) through 30(e) and Employer's Exhibit 60.

^{24/} One of these documents reflects assignments for the fourth floor, one reflects assignments for the second floor and four reflect assignments on the third floor.

The medicine department is located on the second floor of the hospital. Olga Navarro is a staff RN who worked for 2 months in medicine during the Spring of 2001. Navarro testified that in the medicine department, there are 3 RNs per 12-hour shift, 2 or 3 LPNs who work an 8 hour shift beginning at 7 a.m., 2 LPNs who work an 8-hour shift beginning at 3 p.m. and 2 LPNs who work an 8-hour shift beginning at 11 p.m. She related that the night shift general supervisor completes the daily assignment sheet for the medicine department, attempting to equalize the number of patients assigned to the nurses and to rotate the assignment of narcotics count and departmental admissions.

Telemetry is located on the third floor. Morales, the telemetry area supervisor, testified that when she arrives at the department in the morning, she does not know which patients have been assigned to which nurses and that at that time, she verifies which nurses are handling which patients. Olga Navarro, also a staff RN in telemetry, testified that the general supervisors complete the daily assignment sheets for telemetry and medicine by making rounds in the departments, equalizing the number of patients assigned to a particular nurse and that if no assignment sheet is posted at the beginning of the shift, a nurse will contact the general supervisor to make the assignment. It appears that staff RNs have occasionally prepared the daily assignment sheet.

The pediatrics/surgery department, the OB/GYN department and the nursery/delivery room department are located on the fourth floor of the hospital. Staff RN Norva Melendez has worked in all fourth floor areas.^{25/} Melendez testified that the department supervisor prepares the weekly schedule for the nursery (apparently including the delivery room) and that the area supervisor prepares the weekly schedule for pediatrics/surgery-OB/GYN.

Melendez testified that the Employer uses the standard daily assignment sheet to make daily assignments for employees in pediatrics/surgery-OB/GYN; that supervisors (mostly general supervisors on night shift) prepare the daily assignment sheets; that an RN may be assigned to work in any area within pediatrics/surgery-OB/GYN on a particular day; that LPN assignments are contained on the daily assignment form; and that she does not know how it is decided whether she will be working with an LPN on a particular day. Departmental admissions assignments are assigned to RNs on a rotational basis. The lists of specific tasks for RNs and LPNs are not checked on these daily assignment sheets. Melendez testified that in the event a daily assignment sheet is not posted, RNs would contact the area supervisor or the general supervisor who would then make the assignments either by coming to the floor or by informing the RN by phone how the employees should be assigned, in which case the RN would record the assignments on the daily assignment sheet. Melendez referred to such a circumstance as a possible explanation for the appearance of staff RNs' handwriting and signatures on the daily assignment sheets.

^{25/} It appears from Melendez's testimony, that the assignments in the nursery/delivery room are separate from the assignments in pediatrics/surgery-OB/GYN which she spoke of as a group, but her testimony was elicited in this manner as a result of the questions posed to her. Thus, the record is ambiguous as to the organizational structure of the fourth floor operations, particularly in view of the organizational chart and Colon's testimony that pediatrics/surgery is a separate department from OB/GYN.

Melendez testified that the daily assignment sheets in the nursery are placed on a form different from the one for pediatrics/surgery-OB/GYN. The blank nursery daily assignment sheets contain spaces for the assignment of RNs to nursery patients and a list of tasks to be performed by the RNs. Because the normal complement of RNs in the nursery is one per shift, the RN on that shift is normally assigned to all patients in the nursery. A completed nursery daily assignment sheet for November 7, 2001 shows that one RN was assigned to the day shift and one to the night shift. A completed nursery daily assignment sheet for November 8, 2001 shows one RN assigned to the day shift and two RNs assigned to the night shift with a day shift LPN assigned to bathe, feed and take vital signs from the patients.^{26/} All RNs' tasks listed on the blank form were checked on the November 8 assignment sheet but none were on the November 7 sheet.

The ICU daily assignment sheets do not contain LPN assignments.^{27/} Moreover, the sheets are unclear as to whether RNs work together for particular patients. The assignment sheets reflect that ICU has 2 to 4 RNs per shift. In addition to containing the patient classification grid and the assignment of patients to RNs, the assignment sheet also contains entries for assignment of special tasks, such as narcotic count, cleaning and admissions. The special tasks are done every shift but do not relate to the care of a specific patient. The temporary transfer of ICU RNs to other units is reflected on their daily assignment sheet. Colon testified the ICU daily assignment sheets, which include the ICU patient classifications, may be completed by a staff RN or the area supervisor. Alejandro, the ICU area supervisor, testified that the night shift nurse starts work on the daily assignment sheets by classifying patients' needs for the next shift and assigning some of the special activities. Although the day shift nurses make patient assignments for the day shift, the record is in conflict regarding such assignments for the night shift. Further, it appears that the nurses on a particular shift decide among themselves who will assume the leadership and work on preparing the daily assignment sheets in an attempt to equalize the work load among the RNs on duty.

Alejandro testified that in an effort to equalize the work load, the nurses attempt to randomly divide classification 3 patients and classification 4 patients equally among themselves. She testified that when she arrives at work in the morning, she makes her rounds of patients and reviews, evaluates and may correct the daily assignment sheet. Wanda Rivera, a staff RN in ICU, testified that the patient classifications are normally done by the area supervisor when she arrives at the department in the morning unless the supervisor is absent, in which case a staff RN would do it. Rivera explained that most of the staff RNs in ICU have done a patient classification, but that she has done such a classification only a very few times. Rivera related that the patient classifications are almost never done on the night shift. Rivera testified that she had made such patient assignments an undisclosed number of times and that other staff RNs in ICU also make patient assignments. The ICU weekly assignment sheets designate daily assignments for an RN to be the leader of the department and the cardiac arrest (blue code) team

^{26/} As noted above, no LPNs are permanently assigned to the nursery.

^{27/} As noted above, no LPNs are permanently assigned to the ICU. If LPNs are needed in the ICU, an RN may telephonically make such a request of the general supervisor or the nursing director. The record does not reflect how frequently this happens.

and specify which RN should perform the narcotics count. If an RN assigned to one of those tasks is not present in the department on the day assigned, the remaining RNs decide among themselves who will perform the task.

Colon testified that the daily assignments for the OR are made by the area supervisor or by a staff RN if the area supervisor is not present. Daily assignment sheets for the OR department dated April 2, 2001, August 26, 2001 and September 4, 2001 were admitted in evidence. These assignment sheets were all signed by I. D. Perez, staff RN, as the supervisor or person in charge.^{28/} The blank form has places to designate the person in charge from 7 a.m. to 3 p.m., the names of RNs and OR technicians who are assigned to each of the three operating rooms, the names of employees assigned to the endoscopy room, the recovery room, ambulatory surgery and the clinical coordinator. The OR department has 8 RNs and 4 or 5 OR technicians. The blank form also contains a list of tasks to be performed by the employees in each of the areas listed on the form but none of those tasks are checked on the completed forms in evidence. The completed forms indicate that on one of the days, an employee was designated as the 7 a.m. to 3 p.m. person in charge, but there was no such designation on the other 2 days. An RN/OR technician pair was assigned to each of the three operating rooms on all 3 days with one pair remaining constant. The same employee was not always assigned to the same area. However, Perez was assigned to an area on each of the 3 days. I am, however, unable to determine from the completed forms the job classifications of the employees assigned to the endoscopy room, the recovery room and ambulatory surgery, but it would appear that they are RNs.

Rodriguez, the OR area supervisor, testified that the operating room RNs know, on a daily basis, the operating room to which they will be assigned because the operating room assignments are rotated from day-to-day and the RNs decide among themselves which of them will handle a particular operating room as well as the technician assigned to that room. Rodriguez explained that the RNs rotate among all the rooms (possibly including the endoscopy room, the recovery room and ambulatory surgery^{29/}) and that OR technician/RN pairings for operating rooms vary from day to day. The record reflects that in addition to the employees listed on the OR daily assignment sheets, the OR department also has a staff RN in charge of sterile supplies, two sterile supply technicians and an escort, but the record does not reflect whether there are daily or weekly assignment sheets for these employees.

A blank daily assignment sheet for the ER department identifies the supervisor and contains places to enter assignments for the LPN phlebotomist^{30/} and assignments for RNs in triage, cardio/trauma, evaluation and two observation areas. The blank form contains specific tasks assigned to the phlebotomist and each of the RN work areas. Hector Rivera, the ER coordinator, prepares the daily assignment sheet for that department. If no daily assignment

^{28/} Colon testified that because Perez's signature is on the September 4 assignment sheet, Perez was the person who assumed the leadership of the OR on that particular day.

^{29/} The daily assignment sheets show that Fernandez and De Leon were assigned to an operating room on August 26, 2001 and to the endoscopy room on September 4, 2001.

^{30/} Colon is the immediate supervisor of the phlebotomist who is assigned to the emergency room. Colon also supervises other phlebotomists who are attached to the lab, which is apparently not a part of the nursing operation.

sheet is posted, the employees contact the general supervisor who either prepares the schedule or authorizes the employees to do it among themselves. The ER has 5 to 7 staff RNs per 7 a.m. or 7 p.m. shift plus a staff RN on the 11 a.m. shift as well as an undisclosed number of clinical coordinators.

The record does not reflect how weekly or daily assignments are made in admissions or dialysis. There is one RN and one EKG technician in admissions with an unspecified number of RNs in dialysis.

General supervisors are responsible for making rounds in the departments to insure that narcotics counts and crash cart tasks have been performed, that the departments are properly staffed and for finding replacements for absent employees. The general supervisors maintain an on-call list of persons to be called into the hospital.^{31/} The record shows that LPN and RN staffing levels in particular departments may be adjusted on a daily basis by reassigning nurses from one department to another. Nurses report absences to the area or general supervisor. Area supervisors receive and approve vacation requests for nurses, determine when employees take their holidays and schedule employees' CPR training. Area supervisors and general supervisors establish patient to RN ratios for the various departments, approve employee requests to trade shifts, authorize overtime and determine when an LPN will work a double shift.

(d) Responsible Direction:

Colon generally described staff RNs as having an independent role in directing, planning, delegating and evaluating nursing actions; being responsible for the management and direction of patient care; possessing critical judgment^{32/}; supervising and directing the work of other RNs, LPNs, clinical coordinators, escorts and technicians; being in charge of work teams^{33/}; and being responsible for training new employees.

Although the record does not specify, it appears that the role of staff RNs in telemetry, nursery/delivery, medicine, ICU, pediatrics/surgery and OB/GYN, herein called residence units, where patients are assigned to beds and their daily needs are administered, is different from the role of RNs in admissions, the emergency room and the operating room, where patients are temporarily processed or treated and then returned to their assigned beds. Because LPNs are not normally assigned to ICU and nursery/delivery, it would appear that the role of RNs in those two

^{31/} The testimony of Wanda Rivera, a staff RN, concerning the on-call list related to her experience as an acting general supervisor and does not specify the types of persons whose names might appear on the list. The example she gave involved her calling a person from the list to assist with a delivery of a baby.

^{32/} The record indicates that "critical judgment" is a term of art in the health care field, in all likelihood akin to professional judgment described in Section 2(12)(a)(ii) of the Act.

^{33/} The nature of a work team is somewhat murky. Colon described a work team as persons under the supervision of RNs, such as LPNs and technicians. She gave the example of an RN being responsible for an interdisciplinary work team of X-Ray department employees in taking an X-ray of a patient. Norva Melendez, a staff RN, testified that area supervisors are in charge of work teams.

units is different from the role of staff RNs in the other resident units. Most of the LPNs (about 30 of 35) are assigned to the residence units.

The record as a whole shows that the staff RNs in the residence units are the focal point for gathering and disseminating information concerning patient care, receiving and executing medical orders and transmitting medical orders from physicians to other persons who may be responsible for carrying them out. RNs are the primary personnel responsible for providing and coordinating the care of patients and insuring that it is executed and documented.

Hospital administration has developed standardized written protocols^{34/} used by RNs and other employees for the execution or transmission of physician's orders and for the RNs' development and implementation of patient care plans. RNs, LPNs and technicians perform their work according to these standardized protocols.

The code blue (cardiac arrest) protocol admitted in evidence specifies the exact steps employees are to take when a patient is discovered to be without vital signs, lists the employees who participate in responding and specifically describes each task the employee is responsible for performing. The code blue protocol designates the ICU RN as being in charge of directing employees' response until the ER physician arrives.

There were five document forms entitled "Nursing Care Standard" admitted in evidence and referred to as care plans. These documents are just a few among many standardized care plans that exist at the hospital and are maintained for patients in their files. RNs decide whether a particular care plan will be used for a particular patient. For example, the care plan form for patients with ineffectual air passages lists the symptoms as reduction in energy, fatigue, trauma, edema, color, tracheo-bronchial obstruction, tracheo-bronchial secretions, shortness of breath, expressions of anxiety and abnormal arterial gas levels. It provides that nurses will assess and record respiratory sounds, breathing rhythms, expectoration, skin color and arterial gas levels; provide suction; keep patient semi-seated; make oxygen available; instruct patient and family to notify a nurse of increases in breathing difficulty; stay with patient during periods of difficulty to offer emotional support; encourage performance of breathing exercises; instruct the patient on relaxation techniques to improve breathing pattern; maintain a calm and comfortable environment; and coordinate with discharge planner to evaluate need for equipment and follow up at home. The care plan form also contains places for handwritten entries reflecting when and by whom the condition was resolved, the plan was reactivated, or the plan was reviewed. The other care plan forms in evidence relate to patients with altered elimination or diarrhea, fear, improper body temperatures and inability to maintain personal hygiene. None of the care plans in evidence contain handwritten notations.

The record indicates that RNs observe and evaluate patients to make a nursing diagnosis and establish a care plan also referred to as a nursing plan. RNs are responsible for reevaluating and modifying care plans.

^{34/} The protocols described herein do not refer to any specific official hospital document but refer to documents described on the record as protocols, standards, care plans and standard procedures.

RNs and LPNs also use a skin care form which is activated by a physician's order or by an RN upon discovering that a patient might require skin care. RNs initiate the form by indicating the type of skin care required and designating which of four standard bed positions the patient should be placed in at 2-hour intervals. LPNs execute and document the changes of position shown on the skin care form. RNs review the forms and initial to verify that the changes in position have been accomplished. LPNs also record on the skin care form the location and treatment of patient lacerations and wounds as well as any support equipment the LPN offered to the patient.

In addition to the above protocols, other protocols exist at the hospital, such as protocols for isolation measures, myocardial infarctions, low potassium, heart attacks, diabetic ketoacidosis, mechanical ventilators, gastrointestinal bleeding, intubation and the work of OR technicians. These protocols are not described on the record. Each department has a standard procedures manual accessible to all employees, but except for management of equipment, the record does not reflect the specific procedures these manuals contain.

The record describes the interaction of RNs (primarily in residence units) with the EKG technician, respiratory therapy technicians and x-ray technicians. The x-ray and respiratory therapy technicians work in departments outside of nursing operations. These technicians perform their work according to established protocols pursuant to physicians' orders normally transmitted to them via computer or telephone by an RN and a clinical coordinator.^{35/} RNs are responsible for documenting that the technicians' work has been performed as ordered by the physician and for following up with the technicians' respective departments if it has not. RNs may assist these technicians in positioning patients to enable the technicians to perform their work, may stop the procedure to inform a technician when a patient is being handled incorrectly and may notify a supervisor of the improper handling of a patient. RNs evaluate the work of these technicians to the extent that they observe and document the effect of respiratory therapy on the patient's condition and check x-rays to determine whether they satisfy the physician's needs. RNs are not normally in the vicinity of these technicians when they are performing their work.

The operating room operates from 7 a.m. to 3 p.m. on Monday through Friday. Additionally, an RN and an OR technician are on-call for emergency surgeries. The on-call surgical team is activated when the emergency room surgeon, through an emergency room RN, instructs the emergency room clinical coordinator to call in the surgical team.

The job description and evaluation form for OR technicians describes their duties as providing nursing care in the area assigned under the supervision of an RN performing all technical and assistance work in the surgical services department. Many of the tasks performed by the OR technician are in accordance with established standards. Colon testified that the area

^{35/} Colon testified that an emergency room RN may independently determine that a patient presents certain symptoms which, according to established protocols, require that the patient receive an EKG. She also testified that there has to be an intervening order from a doctor for a patient to receive an EKG. Wanda Rivera, an ICU staff RN, testified that RNs may request an EKG if there is a change in the patient's (heart) monitor.

supervisor or the RN assigns the tasks and duties to the OR technician and that the RN in charge of the operating room directs the work of the OR technician during surgery.

The OR technicians are paired with RNs on the daily assignment sheet to provide services in an operating room. The OR technicians are responsible for preparing surgeries in advance by preparing the operating table, taking into account the patient's needs and the physician's routine. In conjunction with the RN they insure that the proper instruments, materials and equipment are assembled in their proper places in the operating room. During surgery, the OR technician hands instruments and materials to the surgeon, maintains the sterile field at all times and in conjunction with the circulating RN counts sponges, needles and instruments. After surgery, the OR technician cleans and disinfects the operating room, equipment and instruments and assists the circulating RN and anesthetist in preparing the patient to be transferred to the recovery room. The OR technician is responsible for maintaining the proper equipment and supplies in the operating room. The circulating RN is responsible for documenting on a standardized form everything that occurs during surgery; overseeing the surgical procedure to insure that the sterile field is not violated and in the event of a violation, recommending that the physician take corrective action which might include halting the procedure; and overseeing the OR technician's count of instruments and materials.

Operating room RNs contact biomedical technicians, either directly or through an OR technician, to request repair of damaged equipment and sign a work order form prepared by the biomedical technician to document that the repair has been accomplished.

The supplemental evaluation form for recovery room RNs indicates that they are responsible for supervising the work of the LPN and escorts and accompanying escorts on patient transfers. Testimony reflects that the recovery room LPN, at the direction of an RN, takes patients' vital signs, assists patients in changing clothing, empties urine bags and transfers patients to and from the OR department.

The daily schedules for the residence units indicate that most but not all LPNs are paired with RNs to provide care to specific patients.^{36/} The job description and evaluation form and the daily assignment sheets for LPNs designate specific tasks which are to be performed by them. The duties and functions of LPNs are assigned by the area supervisor. Although Colon testified that RNs delegate^{37/} these tasks to LPNs, it appears that certain tasks, such as feeding, taking vital signs and bathing are routinely performed on a daily basis by LPNs when they make their

^{36/} Because RNs work 12-hour shifts and the LPN shifts are 8 hours, it appears that the day shift RNs work with day and afternoon shift LPNs, night shift RNs work with afternoon and night shift LPNs, and afternoon shift LPNs work with day and night shift RNs. The record does not explain what happens to RN/LPN pairings when the shifts change.

^{37/} It is clear that Colon's reference to delegation includes an RN instructing an LPN to perform a task pursuant to a physician's order.

rounds. ^{38/} LPNs measure intake and elimination only on a physician's order transmitted to them by the RN. They reposition patients pursuant to a skin care plan initiated by a physician or an RN. LPNs prepare patients for surgery according to the surgery schedule. LPNs ambulate patients at the instruction of RNs and weigh patients pursuant to physicians' orders. LPNs may be instructed on how to feed patients with special devices. An RN may request that an LPN take vital signs more frequently than established by protocol if a patient's vital signs have shown a significant change or if the RN doubts the accuracy of a vital sign measurement. RNs may also direct or guide an LPN in repositioning patients with special conditions or connected to special machinery. RNs intervene in bathing only if the LPNs have doubts as to how to manage patients connected to several machines. Finally, RNs may be present when a patient is bathed to take advantage of an opportunity to observe the condition of a patient's skin. If an RN observes that an LPN has performed a task incorrectly, the RN may correct the LPN. If an LPN fails to perform a task or to report significant changes in a patient's condition, the RN is responsible for notifying the area supervisor using an incident report. RNs may also orient the LPN as to the deficiency.

RNs may also establish priorities for LPNs' work. Examples in the record involved RNs insuring that patients are prepared for surgery on time and asking LPNs to bathe patients before a transfer to the ICU. Colon testified that RNs are continually evaluating the work of the LPNs. The example she gave was the RNs' documentation concerning whether patients' diets were tolerated after being fed by LPNs. Olga Navarro, a staff RN, testified that RNs make sure that treatment rendered by LPNs is effective. RNs may assign an LPN to perform a task listed on the weekly schedule. However, the record reflects that this occurs when the supervisor has failed to assign the task or if the LPN shown on the schedule is absent.

The level of assistance that patients require for feeding, elimination, ambulating and personal hygiene is set forth in the patient classification form. Some of the functions performed by LPNs are listed on care plans. RNs are responsible for maintaining a treatment cardex for each patient on a standardized form to record medical orders, treatments required by patients and the execution of those orders and treatments. LPNs refer to the cardex to determine certain tasks they are to perform, such as frequency of vital signs, patient diet, changes of position and whether the patient is bedridden or ambulatory. It appears that the cardex is a centrally located record system to facilitate the exchange of information without requiring employees to examine individual patient files to determine which tasks need to be performed.

LPNs prepare a report at the end of their shift which shows for each patient the patient category, diagnosis, diet, vital signs, intake, elimination and special treatments. The end of shift report is given to the LPN arriving on the next shift to facilitate communication concerning the

^{38/} In response to a question as to who directs LPNs in performing their tasks, Morales, the telemetry area supervisor, testified that nurses need to make sure that patients get the care that each RN assigns to them aside from the routine duties they have to do. Thus, it appears that there are some tasks that LPNs routinely perform while other tasks are specifically assigned to them by RNs. However, the division between routine and specifically assigned tasks is not entirely clear on the record. For example, Norva Melendez, a staff RN, testified that in pediatrics/surgery-OB/GYN, she might ask an LPN to ambulate a patient, take emergency vital signs or do curations, but the only time she notifies an LPN to carry out a function is when it is part of a doctor's order. Also, Olga Navarro, a staff RN, testified that the only tasks that an RN may delegate to an LPN are emergency vital signs and gastrointestinal signs.

patients' conditions. LPNs prepare end of shift reports for each patient under their care on forms to record the patient's vital signs, intake, elimination and position changes.^{39/} The RNs record LPNs' shift end reports in the treatment cardex.

The LPN phlebotomist in the emergency room works from 2 p.m. to 10 p.m. Her primary function is to collect blood samples pursuant to a physicians' orders at the instruction of RNs, transport the samples to the laboratory and insure that the test results are placed in the patient's medical file. The phlebotomist also attends to patients' basic needs, takes their vital signs and moves them within the emergency room as instructed by RNs.

The clinical coordinators work on the day shift from 7 a.m. to 3 p.m. or afternoon shift from 3 p.m. to 11 p.m. They perform clerical and reception work for various units. Clinical coordinators handle incoming telephone calls, make telephone calls or computer entries as directed by RNs to contact physicians or technician departments. They set up patient files, insure that files are complete and organized and assemble documentation relating to patient transfers. If a clinical coordinator fails to comply with an RN's request for clerical assistance, the RN notifies a supervisor.

Escorts accomplish the physical transfer of patients within the hospital. Patient transfers occur on physicians' orders routed through an RN. RNs from the originating and receiving departments must sign documentation concerning patient transfers which includes a summary of the patient's condition and follow up actions required. Pursuant to physicians' orders, RNs request the services of escorts, may accompany them in executing the transfer and may stop transfers if they determine that the patient is at risk.

RNs are responsible for completing medication requisition forms for their departments which are sent to the pharmacy for processing. RNs may have contact with pharmacy technicians when RNs take physicians' prescriptions to the pharmacy or when pharmacy technicians deliver medicine to an RN.

RNs may request that a social worker interview a patient. This can occur pursuant to a physician's order or if the RN determines that a social worker is needed. RNs notify emergency medical technicians of physician orders to transfer patients to facilities outside of the hospital and they complete portions of forms documenting such transfers.

(e) Admissions RN:

Marisely Rodriguez is the RN in charge of admissions. Colon characterized Rodriguez as non-supervisory. Besides Rodriguez, the EKG technician is the only other employee in the admissions department. Rodriguez works from 7 a.m. to 3:30 p.m. The EKG technician begins work at 7:30 a.m. The job description and evaluation form for the EKG technician describes that person as being assigned to the function of EKG technician to facilitate work of other members of the health care team. The form indicates that the EKG technician, among other things,

^{39/} Colon initially testified that these reports are given to the RN, but subsequently stated that the reports are placed in the patients' file at the end of the shift.

reviews EKG requisitions to insure that they are complete with the patient's information in accordance with the physician's order; maintains EKG equipment, reports defects to the supervisor, orients patients concerning EKG procedures,^{40/} establishes work priorities, adapts to changes in volume of work, carries out duties independently with little or no supervision and performs other tasks as delegated by the supervisor.

Rodriguez's role in performing the evaluation for the EKG technician is described above in connection with the evaluation process. Colon described Rodriguez as being in charge of the EKG technician; evaluating physician orders (EKG requisitions) that are available to the department; and following up on the EKG technician who performs EKGs on patients going to surgery. As more fully described above, most of the EKG technician's work is performed in various patient areas away from the admissions department.

(f) Sterile Supplies RN:

Sonia Rivera is the RN in charge of sterile supplies which is included in the ER department. Two sterile supply technicians who work from 6:30 a.m. to 2:30 p.m. and noon to 8 p.m., respectively, also work in the sterile supplies area located on the first floor of the hospital. Colon described the sterile supply technicians as reporting directly to the RN. The job description and evaluation form for the sterile supply technician describes that person as performing work at the sterile supplies center under the supervision of a professional nurse in order to ensure that procedures are being performed without delays. The form sets forth in minute detail the tasks that the sterile supply technicians are to perform in assembling surgical instruments on surgical trays; labeling and sealing the instruments and trays to ensure that they remain sterile; receiving, inspecting and sterilizing used surgical instruments; replacing deteriorated instruments; maintaining an adequate inventory of instruments; assembling surgical trays, supplies and equipment on surgical carts; prioritizing work according to the surgery schedule; and performing other tasks as delegated by the supervisor.

Rodriguez, the OR area supervisor, testified that Rivera has authority to change the shifts of the sterile supply technicians and has done so on several occasions. Rodriguez explained that the other sterile technician would have to agree to cover the shift in which case a written shift change request may be submitted which Rivera would approve in Rodriguez's absence. Rivera does not have access to the sterile supply technicians' personnel files.

ANALYSIS:

(a) Legal Overview:

Section 2(11) of the Act defines a supervisor as a person:

^{40/} Based on the record as a whole and particularly in view of the fact that the testimony in Spanish was translated to English, it appears the term "orient" may also mean "educate".

. . . having authority in the interest of the employer to hire, transfer, suspend, layoff, recall, promote, discharge, assign, reward or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively recommend such action, if in connection with the foregoing, the exercise of such authority is not merely of a routine or clerical nature, but requires the use of independent judgment. . . .

I note that in enacting Section 2(11) of the Act Congress emphasized its intention that only supervisory personnel vested with “genuine management prerogatives” should be considered supervisors and not “straw bosses, leadmen, set-up men and other minor supervisory employees.” See, **Senate Rep. No. 105, 80th Cong., 1st Sess. 4**, reprinted in **1 NLRB Legislative History of the Labor Management Relations Act, 1947**. See also, *Chicago Metallic Corp.*, 273 NLRB 1677, 1688 (1985); *NLRB v. Bell Aerospace Co.*, 416 NLRB 267, 280-281, 283 (1974). Although the possession of any one of the indicia specified in Section 2(11) of the Act is sufficient to confer supervisory status, such authority must be exercised with independent judgment and not in a routine manner. *Hydro Conduit Corp.*, 254 NLRB 433, 437 (1981). Thus, the exercise of “supervisory authority” in merely a routine, clerical or perfunctory manner does not confer supervisory status. *Feralloy West Corp. and Pohang Steel America*, 277 NLRB 1083, 1084 (1985); *Chicago Metallic Corp.*, supra; *Advanced Mining Group*, 260 NLRB 486, 507 (1982). Moreover, in the event that “the evidence is in conflict or otherwise inconclusive on particular indicia of supervisory authority, [the Board] will find that supervisory status has not been established at least on the basis of those indicia.” *Phelps Community Medical Center*, 295 NLRB 486, 490 (1989). Conclusionary evidence regarding the possession of Section 2(11) indicia, whether the evidence is contained in job descriptions, *Crittendon Hospital*, 328 NLRB 879 (1999), or testimony, *Sears, Roebuck & Co.*, 304 NLRB 193 (1991), is insufficient to establish supervisory status. Thus, where there exists general conclusionary evidence that individuals are responsible for supervising, directing, or instructing others, such evidence, standing alone, is deemed insufficient to prove supervisory status because it does not shed light on exactly what is meant by such general conclusionary words or whether an individual engaging in these activities is required to exercise independent judgment. For example, as the Seventh Circuit aptly noted in *Westinghouse Electric Corp. v. NLRB*, 424 F.2d 1151 (7th Cir. 1970), there is enough play in the meaning of such terms that the Board is not bound to equate them with supervision in the statutory sense.

In reaching my decision with respect to the supervisory status of the RNs in dispute, I must apply the principles established by the Board in the above cases as well as the holding of the Supreme Court in *Kentucky River Community Care, Inc.*, 121 S.Ct. 1863 (2001). Initially, in *Kentucky River*, the Supreme Court approved the Board’s well-established precedent that the party asserting supervisory status has the burden of proof to establish such status. *NLRB v. Kentucky River Community Care, Inc.*, 121 S.Ct. at 1867. Here, the Employer asserts that the RNs are statutory supervisors and therefore bears the burden of proof to establish supervisory status.

A statutory supervisor must possess at least one of the indicia specified in Section 2(11) of the Act. *NLRB v. Kentucky River Community Care, Inc.*, 121 S.Ct. at 1867; *Queen Mary*, 317 NLRB 1302 (1995); *Allen Services Co.*, 314 NLRB 1060 (1994). Moreover, a statutory supervisor must exercise supervisory indicia in a manner requiring the use of independent

judgment. With respect to most Section 2(11) indicia, the use of independent judgment is self-evident. However, when considering the supervisory authority to responsibly direct, it is more difficult, particularly in the health care industry, to define the use of independent judgment. In the health care field, the Board previously held that employees do not use independent discretion when they exercise ordinary professional or technical judgment in directing less skilled employees to deliver services in accordance with employer specified standards. In *Kentucky River*, the Supreme Court rejected this categorical exclusion. Rather, the Supreme Court found that such a categorical exclusion was improper, overbroad and “contrary to the statutory language.” *NLRB v. Kentucky River Community Care, Inc.*, 121 S.Ct. at 1871.

Although the Supreme Court rejected the Board’s categorical exclusion of professional judgment from Section 2(11) independent judgment, it did accept two aspects of the Board’s interpretation of independent judgment. The Supreme Court agreed with the Board that independent judgment is ambiguous and that many nominal supervisory functions may be performed without the exercise of such a degree of judgment or discretion as would warrant a finding of supervisory status under the Act. *NLRB v. Kentucky River Community Care, Inc.*, 121 S.Ct. at 1867. The Supreme Court also recognized that judgment may be reduced below the statutory supervisory threshold by detailed regulations issued by an employer. *Id.* See also *Dynamic Science, Inc.*, 334 NLRB No. 57 (2001) (citing *Kentucky River*). Moreover, in *Kentucky River*, the Supreme Court held that the Board has discretion to determine the scope of judgment that qualifies as independent judgment within the meaning of Section 2(11) of the Act.

In *Kentucky River*, the Supreme Court noted that the Board defended its categorical exclusion based on policy considerations because it sought to preserve the inclusion of professional employees within the coverage of the Act. *NLRB v. Kentucky River Community Care Inc.*, 121 S.Ct. at 1870. The Supreme Court found that the question presented did not involve the soundness of that labor policy which the Board was entitled to judge without second-guessing by the Court. Rather, the Supreme Court noted that the policy could not be given effect through the categorical exclusion of professional judgment from the meaning of independent judgment contained in Section 2(11) of the Act. The Supreme Court, citing *Providence Hospital*, 320 NLRB 717, 729 (1996), went on to suggest that the policy favoring the Act’s coverage of professional employees might be accomplished by developing a “limiting interpretation of the supervisory function of responsible direction” that distinguishes employees who direct the manner of others’ performance of discrete tasks from employees who direct other employees. *NLRB v. Kentucky River Community Care, Inc.*, 121 S.Ct. at 1871.

In *Kentucky River*, the Supreme Court did not hold that all nurses are supervisors. Indeed, the Court did not even discuss the job duties of the nurses at issue nor did it decide whether those individuals are supervisors. Thus, the determination of the supervisory status of nurses and other individuals remains a fact-specific inquiry.

(b) Area Supervisors and General Supervisors:

The Employer maintains that all the RNs are statutory supervisors. Because all the area supervisors as well as general supervisors are RNs, it follows that the Employer’s position is that all of the area supervisors and general supervisors are statutory supervisors. In the conclusionary

portion of its brief, the Petitioner urges me to find that the staff RNs are statutory employees. The parties' use of the term staff RN on the record does not include area supervisors or general supervisors. It would appear, therefore, that the Petitioner does not dispute the Employer's assertion that the area supervisors and general supervisors are supervisors within the meaning of Section 2(11) of the Act. In any event, the job description and evaluation forms for the area supervisors and general supervisors, as well as record testimony, indicate that they possess statutory supervisory indicia requiring the exercise of independent judgment. Indeed, the parties stipulated that some of the RN area supervisors are supervisors within the meaning of the Act and there is no indication on the record that the supervisory status of any of those individuals is in dispute. Moreover, there is no evidence that the authority of any of the area supervisors whose Section 2(11) status was stipulated is different from the authority of the area supervisors whose status was not stipulated.

Under these circumstances, I conclude, in apparent agreement with the parties, that the area supervisors and general supervisors are supervisors within the meaning of Section 2(11) of the Act. Accordingly, I shall exclude them from the unit.

(c) Staff RNs:

In analyzing the supervisory status of the staff RNs, I have carefully considered the four Section 2(11) indicia, evaluation, discipline, assignment and responsible direction, which the Employer maintains the RNs possess and exercise. There is no evidence that the staff RNs possess the authority to hire or fire or possess any supervisory indicia other than the four criteria relied on by the Employer.

(i) Evaluation:

The record regarding the staff RNs' role in evaluating employees does not reflect the type of supervisory indicia referred to in Section 2(11) of the Act. Rather, the evidence is limited to general testimony that staff RNs make oral representations to area supervisors concerning the job performance of other employees and that evaluations are used to determine wage increases granted to employees. The record does not generally disclose what weight, if any, is given to the staff RNs' oral representations in arriving at a final evaluation. The only specific evidence regarding the role of staff RNs in determining wage increases resulting from evaluations is that they have no such role with respect to technicians. The record is unclear whether this lack of involvement in wage increases extends to employees in general. The record contains evidence with respect to the processing of only one specific evaluation. In that instance, Colon reviewed and revised the employee's evaluation, indicating that Colon exercised her own independent judgment in the final version of the evaluation and that any recommendations or input by staff RNs were not effective. Thus, with respect to the evaluation of employees, the evidence fails to establish that the RNs' oral representations to area supervisors constitute effective recommendations or that such recommendations require the exercise of any supervisory indicia. Both elements must be established before supervisory status is conferred. *Children's Farm Home*, 324 NLRB 61 (1997); *Harborside Healthcare, Inc.*, 330 NLRB No. 191 (2000). Accordingly, the Employer has not met its burden of establishing that the staff RNs exercise or

possess supervisory indicia in the evaluation of employees. *NLRB v. Kentucky River Community Care, Inc.*, 121 S.Ct. at 1867.

(ii) Discipline:

The evidence concerning discipline issued to employees suggests that the staff RNs' role is limited to either the preparation and submission of incident reports, which any employee may prepare and submit, or to their attempts to correct perceived deficiencies in the work of other employees. The record shows that incident reports, whether prepared by staff RNs or other employees, are independently investigated by area supervisors. The record discloses that if the RNs are unable to correct such problems, area supervisors engage in follow up. There is no evidence that staff RNs make recommendations as to adverse employment actions in submitting incident reports or reporting deficiencies to area supervisors. Based upon a careful review of the record, it is apparent that these limited corrective and reportorial functions by staff RNs are not indicative of supervisory status because they do not involve the imposition or recommendation of adverse employment actions and do not, therefore, constitute discipline. *Crittendon Hospital*, 328 NLRB 897 (1999); *Illinois Veterans Home*, 323 NLRB 890 (1997).

The Employer relies on *NLRB v. Quinnipiac College*, 256 F.3d 68 (2nd Cir. 2001) and *ITT Lighting Fixtures v. NLRB*, 712 F.2d 40 (2nd Cir. 1983) for the proposition that the Act does not preclude supervisory status simply because the recommendation for discipline is subject to a superior's investigation. Although I am bound to follow Board precedent rather than that of the Second Circuit, I note that the Court recognized in *Quinnipiac* that where, as here, an employee notifies management of an employee problem without making a recommendation as to discipline, supervisory authority is not exercised. In *ITT*, the person found by the Court to be a supervisor possessed authority to issue oral warnings and to recommend written warnings. Here there is no evidence that staff RNs make recommendations as to disciplinary action regarding other employees. Thus, the Employer has not met its burden of establishing that the staff RNs exercise or possess supervisory indicia in the discipline of employees. *NLRB v. Kentucky River Community Care, Inc.*, 121 S.Ct. at 1867.

(iii) Assignment:

The evidence also fails to establish that the staff RNs assign employees requiring the use of independent judgment. The weekly schedules used to assign employees to a particular shift and department are prepared by the area supervisors. It appears that the general supervisors are responsible for any daily changes to the weekly schedule necessitated by the need to balance RNs among departments according to patient load. The daily assignment sheets, which assign particular patients to specific nurses, are prepared mostly by area supervisors and general supervisors. Although the record indicates that staff RNs may prepare daily assignment sheets, it appears that they do so by consensus among those who will be affected by the assignments and that the assignments are designed to equalize the patient load among the affected employees. Such decision making by consensus is not indicative of supervisory authority and assignments based on equalization of work do not require the use of independent judgment. *Providence Hospital*, 320 NLRB at 727; *Parkview Manor*, 321 NLRB 477, 478 (1996); *Ten Broeck Commons*, 320 NLRB 806, 810 (1996) (charge nurses' assignment of work to assistants did not

require the use of independent judgment because assistants had the same skills and were routinely rotated). Other assignment functions such as calling in employees to fill in for absences, approval of vacation requests, shift trades, holiday time off and overtime are handled by area and general supervisors rather than by staff RNs. Thus, the Employer has not met its burden of establishing that the staff RNs exercise or possess supervisory indicia in the assignment of employees. *NLRB v. Kentucky River Community Care, Inc.*, 121 S.Ct. at 1867.

(iv) Responsible Direction:

Having carefully considered the entire record, I further find that the evidence is insufficient to conclude that the staff RNs possess authority to responsibly direct employees requiring the use of independent judgment. To be sure, the staff RNs, as professional employees, exercise judgment and discretion in the performance of their patient care duties but the extent to which they do so is not clearly set forth on the record. Moreover, the record shows that staff RNs communicate to other employees the need for them to perform discrete patient care tasks. However, the fact that the RNs are required to use judgment and discretion in the performance of their work coupled with the fact that they communicate patient care needs to other employees does not necessarily establish that the RNs exercise independent judgment in the direction of other employees. For example, when an RN informs the respiratory therapy department of a physician's order that a patient needs respiratory therapy, the RN is engaging in conduct which will cause another employee to perform a specific task, but such action does not require the use of independent judgment. Rather, the RN is merely a conduit for communicating the instructions of the physician and is not deciding which employee will perform the task or how the task will be performed. The record discloses that staff RNs may make decisions requiring independent judgment with regard to the care of patients. However, the exercise of this type of independent judgment does not necessarily establish supervisory status. There is no evidence that the discretion exercised by staff RNs in making patient care decisions requires the use of independent judgment in the direction of other employees who execute patient care.

The record shows that the staff RNs, on occasion, independently make patient care decisions which cause other employees to perform specific tasks. For example, a staff RN's decision to implement specific protocols, the completion of patient classification forms and decisions to request treatments or tests administered by technicians may result in other employees being required to perform certain tasks. ^{41/} I note that the protocols set forth patient symptoms which call for the implementation of specific patient care, but it would appear, based on the staff RNs' professional status, that they exercise some discretion in determining whether a particular patient is presenting such symptoms in the first instance. ^{42/} However, the evidence

^{41/} As noted above, most of the technicians' work is performed pursuant to physicians' orders, but staff RNs, in limited circumstances, may independently request the services of technicians.

^{42/} The Employer's brief correctly cites *NLRB v. Quinnipiac College*, 256 F.3d. 68, 75 (2nd Cir. 2001) for the proposition that the existence of governing policies and procedures and the exercise of independent judgment are not mutually exclusive. However, although the staff RNs here exercise an undisclosed degree of discretion in making patient care decisions despite the existence of the protocols, the exercise of patient care discretion does not necessarily translate to the use of independent judgment in responsibly directing employees.

shows that any discretion exercised by the staff RNs is constrained by physicians' orders and detailed protocols setting forth diagnostic as well as treatment standards.

The staff RNs' discretion in directing other employees is further limited by specific written delineations as to which employees are to perform which patient care functions. Thus, for example, there is a specific detailed division between the tasks that are to be performed by staff RNs and those to be performed by LPNs. When a staff RN determines that there is a need for a specific patient care task to be performed, whether such determination is a result of a physician order, contained in a protocol or as a result of the RN's exercise of discretion, the RN's direction that the task be performed is constrained both by the delineation of tasks between RNs and LPNs and by the fact that there is only one LPN to whom the task might be assigned. Under such circumstances, the RNs have no discretion to decide who will perform the task.

It also appears that in some circumstances, a staff RN on one shift may make a patient care decision which will cause an RN or an LPN on another shift to perform certain tasks. However, these decisions, again, do not involve the selection of a particular employee to perform the task, in part, because frequently only an RN is assigned to a particular patient on a particular shift. Further, where both an LPN and an RN are assigned to a patient, the responsibility of each to perform specific duties or tasks is predetermined. Where a staff RN decides that a particular patient requires standing orders for such things as bed repositioning or ambulating on a repeated basis, the decision may be made without any notion of the particular employee who will perform the task in the future because it appears that nurse/patient assignments are made on a daily rotating basis. See *Chevron Shipping Co.*, 317 NLRB 379, 381 (1995); *Dynamic Science*, supra.

More generally, the record shows that the RNs may make patient care decisions which cause employees in other classifications to perform discrete tasks. However, such tasks are set forth in detailed protocols and the employees executing the protocols are trained to perform them as part of their normal and routine job duties. The decision as to whether a patient care task will be performed by an RN, an LPN, a technical employee, a clinical coordinator or an escort is predetermined by the detailed delineation of tasks preassigned to specific job classifications. There is no evidence that staff RNs exercise discretion in the selection of a particular employee within one of those classifications to perform a particular task. With respect to other RNs, LPNs or clinical coordinators, it appears that only one person, within each of those classifications, would be responsible for executing any task that may result from a particular staff RN's exercise of patient care discretion. Moreover, the record indicates that the selection of a specific technical employee to perform a particular patient care task is done by the technical departments rather than the staff RNs. The discretion exercised by the staff RNs with respect to directing employees is, therefore, significantly constrained by the delineation of patient care tasks among the various job classifications, the detailed protocols under which employees perform the tasks as a part of their normal and routine job functions and the lack of RNs' discretion to select specific employees to perform particular tasks. Independent judgment is not required when requesting an employee to perform a specific task if the employee's responsibility for performing the task has been predetermined. *Western Union Telegraph Company*, 242 NLRB 825 (1979). Indeed, the Supreme Court in *Kentucky River* held that it falls clearly within the Board's discretion to determine, within reason, what scope of discretion qualifies as independent judgment within the

meaning of Section 2(11) of the Act. *NLRB v. Kentucky River Community Care, Inc.*, 121 S.Ct. at 1867.

Based upon a careful review of the record, I recognize that the staff RNs exercise discretion in making patient care decisions and that the tasks they cause others to perform are of critical importance to the health of patients. However, this does not mean that directing others to perform such tasks involves the use of independent judgment in the statutory sense. As the Board observed in considering a treatment plan devised by a charge nurse in *Ten Broeck Commons*, 320 NLRB 806, 811 (1996):

There is an important distinction between designing complex work tasks and directing employees in carrying out those tasks. If this distinction is blurred, it becomes easy to be misled into concluding that an individual exercises independent judgment based simply on the fact that the work tasks being designed by that individual are relatively "complex" or "important." . . .

Accordingly, the fact that severe adverse consequences might flow from an employee's routine direction or monitoring of the work of others does not, without more, make the employee a supervisor.

Applying this important distinction to the facts presented here, I conclude that any patient care discretion exercised by staff RNs which may cause another employee to perform a discrete patient care task does not necessarily translate to the exercise of independent judgment in responsibly directing employees. Although there is a causal link between a staff RN's patient care decisions and tasks performed by other employees, the discretion involved in the causal link is significantly constrained by standardized protocols, predetermined areas of work responsibility and the lack of the RN's discretion to select or direct specific employees to perform needed tasks. The question is not whether staff RNs utilize discretion and independent judgment to determine and treat patients' medical conditions, but rather whether the staff RNs exercise Section 2(11) independent judgment in responsibly directing employees to execute patient care tasks. Here, once a staff RN makes a complex and important assessment regarding the care of a patient which may require the exercise of discretion, the staff RN thereafter exercises little discretion and utilizes minimal judgment in directing employees in carrying out patient care tasks. Thus, the staff RNs' discretion in responsibly directing employees is severely constrained by procedures and protocols which predetermine the classification of employee who will perform the task and the manner in which the task is to be performed. Moreover, the evidence does not establish that the staff RNs have discretion to select which employee, within a given classification, will perform the work. Under these circumstances, the staff RNs' direction of others is constrained to such a significant degree that it is rendered routine. *Dynamic Science*, supra; *Chevron Shipping*, supra.

Although staff RNs are responsible for insuring that patient care tasks are executed and that they are performed in a proper manner, the mere act of determining whether particular patient care tasks have, in fact, been performed does not require the use of independent judgment where the performance of such tasks is documented and therefore readily ascertainable without

exercising discretion. Staff RNs also observe the work of LPNs to determine whether it has been performed correctly and may instruct an LPN in the correct manner in which to perform patient care tasks. However, the LPNs' work is routinely performed on a day-to-day basis and there is no evidence that the RNs use independent judgment in directing the LPNs to perform such tasks or to perform them correctly. It appears that the RNs' role amounts to nothing more than the exercise of greater skill and experience in helping less skilled employees perform their work. *Northern Montana Health Care*, 324 NLRB 752, 753 (1997); *Ten Broeck Commons*, 320 NLRB at 810-812. The Supreme Court recognized this principle in *Kentucky River*, by suggesting that the Board might draw a distinction between directing the manner in which employees perform discrete tasks and directing employees as Section 2(11) of the Act requires.

Finally, staff RNs may assist technical employees in positioning patients to enable the technical employees to perform patient care procedures and may advise technical employees of the manner in which a particular patient should be handled. The evidence does not suggest, however, that RNs become involved in the manner in which the technical employees' procedures are actually performed. The RNs' involvement in positioning patients for the administration of technical procedures, therefore, appears to be more collaborative than supervisory in the statutory sense because the RNs lack involvement in the manner in which the procedures are performed. Although RNs evaluate the effect of technical procedures on the medical condition of patients, there is no evidence that they evaluate the manner in which a technical employee's work is performed. The evidence does not, therefore, establish that the RNs are required to exercise independent judgment with respect to the manner in which technical employees perform their work.

(v) Conclusion As To Staff RNs:

Based on the foregoing, the entire record and careful consideration of the arguments of the parties at the hearing and in the briefs, I find that the evidence fails to establish that the staff RNs are supervisors within the meaning of Section 2(11) of the Act. Their role in evaluations and disciplinary matters does not amount to effective recommendation and they are not required to exercise independent judgment in the limited circumstances in which they assign other employees. Although it appears that the staff RNs exercise a degree of patient care discretion which may result in other employees performing discrete tasks, the evidence fails to demonstrate that the discretion is exercised regarding the responsible direction of employees. Indeed the standardized protocols and patient care plans followed by the patient care providers narrowly circumscribe the ability of the staff RNs to exercise Section 2(11) independent judgment. See *Providence Hospital*, supra; *Ten Broeck Commons*, supra. Accordingly, I find that the Employer has not met its burden to establish that the staff RNs are supervisors within the meaning of Section 2(11) of the Act. *NLRB v. Kentucky River Community Care, Inc.*, 121 S.Ct. at 1867.

(d) Emergency Room Shift Coordinator, Sterile Supply RN and Admissions RN:

The record does not disclose whether the supervisory status of the emergency room shift coordinator, the sterile supply RN, or the admissions RN is in dispute. Although the evidence indicates that these individuals may possess some of the indicia of supervisory status set forth in Section 2(11) of the Act, the record was not sufficiently developed to enable me to determine

with any degree of accuracy whether such authority requires the use of independent judgment. Accordingly, I am unable to determine the supervisory status of the emergency room shift coordinator, the sterile supply RN and the admissions RN and shall permit them to vote in the election hereinafter directed subject to challenge by the Board Agent conducting the election.

CONCLUSION:

Based on the foregoing, the record as a whole and careful consideration of the arguments of the parties at the hearing and in the briefs, I find that the following employees of the Employer constitute a unit appropriate for the purposes of collective bargaining:

All registered nurses employed by the Employer at its Cayey, Puerto Rico facility, but excluding all managerial employees, all other employees, all guards, area supervisors, general supervisors and all other supervisors as defined in the Act.

Accordingly, I shall direct an election among the employees in such unit.

DIRECTION OF ELECTION

An election by secret ballot shall be conducted by the Regional Director of Region 24 among the employees in the unit found appropriate at the time and place set forth in the notice of election to be issued subsequently, subject to the Board's Rules and Regulations. Eligible to vote are those in the unit who were employed during the payroll period ending immediately preceding the date of this Decision, including employees who did not work during that period because they were ill, on vacation, or temporarily laid off. Also eligible are employees engaged in an economic strike which commenced less than 12 months before the election date and who retained their status as such during the eligibility period and their replacements. Those in the military services of the United States may vote if they appear in person at the polls. Ineligible to vote are employees who have quit or been discharged for cause since the designated payroll period, employees engaged in a strike who have been discharged for cause since the commencement thereof and who have not been rehired or reinstated before the election date, and employees engaged in an economic strike which commenced more than 12 months before the election date and who have been permanently replaced. Those eligible shall vote whether or not they desire to be represented for collective bargaining purposes by **Federacion Central de Trabajadores UFCW, Local 481, AFL-CIO.**

LIST OF ELIGIBLE VOTERS

In order to insure that all eligible voters may have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties to the election should have access to a list of voters using full names, not initials, and their addresses which may be used to communicate with them. *Excelsior Underwear, Inc.*, 156 NLRB 1236 (1966); *NLRB v. Wyman-Gordon Company*, 394 U.S. 759 (1969); *North Macon Health Care Facility*, 315 NLRB No. 359 (1994). Accordingly, it is hereby directed that within 7 days of the date of this Decision

2 copies of an election eligibility list, containing the full names and addresses of all the eligible voters, shall be filed by the Employer with the Regional Director for Region 24 who shall make the list available to all parties to the election subject to the Petitioner's submission of an adequate showing of interest. In order to be timely filed, such list must be received in Region 24, National Labor Relations Board, La Torre de Plaza, Suite 1002, 525 F.D. Roosevelt Avenue, Hayto Rey, Puerto Rico 00918-1002, on or before **February 28, 2002**. No extension of time to file this list shall be granted except in extraordinary circumstances, nor shall the filing of a request for review operate to stay the requirement here imposed.

RIGHT TO REQUEST REVIEW

Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the Executive Secretary, 1099 - 14th Street, N.W., Washington, D.C. 20570. This request must be received by the Board in Washington by **March 7, 2002**.

Dated at Cincinnati, Ohio this 21st day of February 2002.

/s/ Richard L. Ahearn

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